SEE LAST PAGE FOR THE PAPERWORK REDUCTION ACT AND PRIVACY ACT AND INFORMATION REGARDING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER

INSTRUCTIONS: Please complete this application in sufficient detail to enable AG Healthcare Staffing Solutions to determine your ability to be hired for employment with AG Healthcare Staffing Solutions. Type, or print in blue/black ink. If additional space is required, please attach a separate sheet and refer to items being answered by number.

1. NAME (Last, First, Middle)

____________________ ________________ ______________

2. SOCIAL SECURITY NUMBER

________ - ______ - _________

3. CURRENT ADDRESS (Street Address)

____

City ______________ State _____ Zip Code ________

4. TELEPHONE NUMBER

______ - ______ - ________

5. DATE OF BIRTH (mm/dd/yyyy)

_____ / _____ / _______

6. PLACE OF BIRTH ______________ **STATE** _____ **COUNTRY** ________

7. CITIZENSHIP

U.S. Born Citizen Not A U.S. Citizen

Country you are a citizen ________________

I - LICENSE

8a. LIST ALL STATES IN WHICH YOU ARE LICENSED IN	8b. LICENSE NUMBER	8c. EXPIRATION DATE

9. DO YOU HAVE A RESTRICTED, LIMITED, OR PROBATIONAL LICENSE?

YES (If "YES" explain on separate sheet) NO

10. HAVE YOU EVER HAD YOUR LICENSE REVOKED, SUSPENDED, OR DENIED?

YES (If "yes" explain on separate sheet) NO

II - EDUCATION

11a. NAME OF SCHOOL	11b. ADDRESS (City, State and Zip Code)	11c. DATE	11d. DIPLOMA

11e. OTHER CERTIFICATION	11f. EXPIRATION DATE
	____ / ____ / _____
	____ / ____ / _____
	____ / ____ / _____
	____ / ____ / _____

III - EXPERIENCE

12a. Employer | **Address (City, State and Zip Code)** | **Employment Dates**

__________________ __________________________________ **From** ________ **To**________

Title & Duties | **Supervisor's Name** | **Telephone Number**

______________________ __________________________________ ______ - ______ - ________

12b. Employer | **Address (City, State and Zip Code)** | **Employment Dates**

__________________ __________________________________ **From** ________ **To**________

Title & Duties | **Supervisor's Name** | **Telephone Number**

______________________ __________________________________ ______ - ______ - ________

12c. Employer | **Address (City, State and Zip Code)** | **Employment Dates**

__________________ __________________________________ **From** ________ **To**________

Title & Duties | **Supervisor's Name** | **Telephone Number**

______________________ __________________________________ ______ - ______ - ________

IV - REFERENCES

NOTE: PROVIDE THE NAMES OF FOUR PERSON NOT RELATED TO YOU DURING THE PAST FIVE YEARS.

13a. NAME	**13b. ADDRESS** (Street, City, State and Zip Code)	**13c. PHONE NUMBER**
		____ - _____ - _____
		____ - _____ - _____
		____ - _____ - _____
		____ - _____ - _____

PLACE AN "X" IF "YES" EXPLAIN DETAILS ON SEPARATE SHEET OF PAPER

14. Within the last five years have you been discharged from any position for any reason **YES** ___ **NO** ___

15. Have you ever been convicted, or are you now under charges for any felony or any firearms or explosives offense against the law? **YES** ___ **NO** ___

V - SIGNATURE OF APPLICANT

NOTE: A FALSE STATEMENT ON ANY PART OF THIS APPLICATION MAY BE GROUNDS FOR NOT HIRING YOUR, OR IMMEDIATE TERMINATION AFTER YOU BEGIN WORK

CERTIFICATION: I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL OF MY STATEMENTS ARE TRUE, CORRECT, COMPLETE, AND MADE IN GOOD FAITH

16. SIGNATURE OF APPLICANT __________________________________ DATE ______________

AUTHORIZATION FOR RELEASE OF INFORMATION

In order for AG Healthcare Staffing Solutions to access and verify my educational background, professional qualification and suitability for employment, I ___________________________________

_____ Authorize AG Healthcare Staffing Solutions to make inquiries concerning such information about me to my previous employer(s), current employer, educational institutions, state licensing boards, and to any other appropriate sources to whom AG Healthcare Staffing Solutions may be referred by those contacted or deemed appropriate.

_____ Authorize release of such information and copies of related records and/or documents to AG Healthcare Staffing Solutions.

_____ Release from liability all those who provide information to AG Healthcare Staffing Solutions in good faith and without malice in response to such inquiries.

_____ Authorize AG Healthcare Staffing Solutions to disclose to such persons, employers, institutions, boards or agencies identifying and other information about me to enable AG Healthcare Staffing Solutions.

SIGNATURE OF APPLICANT _____________________________________ DATE ____________

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

AUTHORITY: The information requested on the attached application form and Authorization for Release of Information is solicited under Title 38, United States Code, Chapters 73 and 74.

PURPOSES AND USES: The information requested on the application is collected primarily to determine your qualifications and suitability for employment. If you are employed by the VA, the information will be used to make pay and benefit determinations and, as necessary, in personnel administration processes carried out in accordance with established regulations and published notices of systems of records.

ROUTINE USES: Information on the form or the form itself may be released without your prior consent outside the VA to another Federal, State or local agency, to the National Practitioner Data Bank which is administered by the Department of Health and Human Services, to State licensing boards, and/or appropriate professional organizations or agencies to assist the VA in determining your suitability for hiring and for employment, to periodically verify, evaluate and update your clinical privileges and licensure status, to report apparent or potential violations of law, to provide statistical data upon proper request, or to provide information to a Congressional office in response to an inquiry made at your request. Such information may also be released without your prior consent to Federal agencies, State licensing boards, or similar boards or entities, in connection with the VA's reporting of information concerning your separation or resignation as a professional staff member under circumstances which raise serious concerns about your professional competence. Information concerning payments related to malpractice claims and adverse actions which affect clinical privileges also may be released to State licensing boards and the National Practitioner Data Bank. The information you supply may be verified through a computer matching program at any time.

EFFECTS OF NON-DISCLOSURE: See statement below concerning disclosure of your social security number. Disclosure of the other information is voluntary; however, failure to provide this information may delay or make impossible the proper application of Civil Service rules and regulations and VA personnel policies and thus may prevent you from obtaining employment, employees benefits, or other entitlements.

INFORMATION REGARDING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER UNDER PUBLIC LAW 93-579 SECTION 7(b)

Disclosure of your SSN (social security number) is mandatory to obtain the employment and related benefits that you are seeking. Solicitation of the SSN is authorized under the provisions of Executive Order 9397, dated November 22, 1943. The SSN is used as an identifier throughout your Federal career from the time of application through retirement. It will be used primarily to identify your records. The SSN also will be used by Federal agencies in connection with lawful requests for information about you from your former employers, educational institutions, and financial or other organizations. The information gathered through the use of the number will be used only as necessary in personnel administration processes carried out in accordance with established regulations and published notices of systems of records. The SSN also will be used for the selection of persons to be included in statistical studies of personnel management matters. The use of the SSN is made necessary because of the large number of present and former Federal employees and applicants who have identical names and birth dates, and whose identities can only be distinguished by the SSN.